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12

The Schizoid Personality

The people we have designated as hysterical and depressive personalities are predominantly extraverted, and share an obvious concern with their relationships with other people. Hysterics seem principally concerned with obtaining attention, whilst depressives are more preoccupied with gaining approval. Both kinds of person have difficulty in managing aggressive impulses towards others. Hysterics tend to criticise the objects of their affections for not living up to their imagined ideals; whilst depressives turn their criticisms against themselves. Both are dependent, and fear being abandoned by those upon whom their happiness seems to depend, and therefore spend most of their time in psychotherapy discussing their interpersonal relationships.

Obsessional personalities, on the whole, are more independent. As we have seen, their attitudes constitute defences against the emergence of hostility in interpersonal relationships, and they therefore tend either to placate others, or else to tyrannise them in the same way that they exert tyrannical control over themselves. These attitudes tend to keep others rather more at a distance; and it is characteristic of obsessionals to spend more time discussing their work and other relatively impersonal topics than do hysterics or depressives. Some obsessionals are more concerned with controlling their own hostility, and thus may be said to be closer to the depressive end of the scale: whilst others are more perturbed by the supposed hostil-

ity of other people, and are thus closer to becoming paranoid. However, obsessionals do behave as if hostility on either side was generally controllable; and thus are able to maintain their relations with other people, albeit in what is often a rather rigid and formalised manner.

There is, however, a more deeply disturbed type of person whose fear of involvement with others is so extreme that he withdraws into himself and attempts to do without human relationships as far as possible. These are the people we call schizoid. Schizoid people come to the attention of psychotherapists in a variety of ways. Because they have little faith in the ability of others to understand or help them, they are often pressed into seeking help by those who are near enough to them to realise that there is something wrong. Thus, to take a characteristic example, an undergraduate who is failing at his work and who shows no signs of being able to make friends or enjoy university life may be steered into psychotherapy by a tutor. This will constitute an additional difficulty in therapy, though not necessarily an insurmountable one. If self-referred, such a patient will complain of not being able to make relationships, especially with the opposite sex; or of being quite unable to concentrate on work or complete work; or of what he is likely to call depression.

Although schizoid patients do indeed become depressed, their mood is often more of apathy than melancholia. As Fairbairn has aptly observed, the 'characteristic affect of the schizoid state is undoubtedly a sense of futility'[1]. Although schizoid people may at first sight resemble depressed patients, one quickly comes to realise that their kind of depression has a quality of meaninglessness which is not present in the ordinary case of depression. Depressives, one feels, are suffering from an interruption or bad episode in their lives; and their resentment can be felt to be just below the surface. With schizoid people, one feels that their mood of futility is much more integral to their ordinary adaptation; almost as if their lives never had had much meaning.

Schizoid people are often difficult to interview. The therapist feels that he is 'not on the same wave-length'. When trying to take a history, he is likely to feel that, although the patient may be superficially co-operative in answering questions, he doesn't

really 'give' anything. The patient may induce in the interviewer the feeling that, in answer to every query, he is really wanting to say: 'what on earth is the point of asking me that?' Some schizoid patients appear to affect an air of superiority, especially if, as is not infrequent, they are intellectually superior, and have made their chief adaptation to the world by means of their brains rather than their feelings. It is important not to allow oneself to be put off by this. Therapists like to have their efforts appreciated, and it is disconcerting to be faced with an individual who appears to repudiate every attempt to get to know and understand him.

It is important to realise that patients of this kind are deeply frightened of any kind of intimacy. Their defence is to withdraw as far as possible from emotional involvement. But since it is emotional involvement which gives meaning to life, they are constantly threatened with finding life meaningless. If the therapist is sufficiently mature to tolerate being repudiated and made to feel useless by such patients, he will find them of great interest, and, if he manages to penetrate their defences, will find himself richly rewarded by winning the trust of someone who for years has found it difficult to trust any other human being.

Why are persons of this kind so reluctant to allow anyone to become close to them? There seem to me to be three main types of fear of intimacy. All three may be present together; but one type is often more manifest than the others. First, a person may be reluctant to embark upon a relationship because he fears that it will end, and that he will therefore be worse off than if he had never taken the risk of involvement. This fear is often based upon an actual experience of loss in early childhood. Isaac Newton, for example, showed many schizoid traits of character. He was notably isolated, and never made any close emotional relationships with anyone of either sex. He was also extremely suspicious, reluctant to publish his work, and prone to accuse others of having stolen his discoveries. When he was just over fifty, he had a psychotic breakdown in which paranoid ideas were prominent. At least some of his emotional difficulties may reasonably be assumed to have taken origin from the experience of his early childhood. Newton was a premature child whose father had died before he was born. For the first

three years of his life, he enjoyed the undivided attention of his mother. Then, when he was just past his third birthday, his mother remarried. She not only presented Newton with an unwanted stepfather, but added insult to injury by abandoning him, leaving him to be brought up by his maternal grandmother whilst she herself moved to live in a different house with her new husband. We know from his own writings that Newton felt this to be a betrayal. He seems never entirely to have trusted any human being again.[2]

A second reason for avoiding intimacy is the fear of being dominated and overborne by the other person to the point of losing identity as a separate individual. We all begin life being at the mercy of adults who are much more powerful that we are, and we all strive, in varying ways, to reach a degree of independence. Although some people wish to continue to be subject to the authority of others, and to have many of the decisions of life made for them, even the most masochistic prefer to retain some autonomy. This can be detected in very small children, and many children's games are concerned with demonstrating that they can put down adults and be 'king of the castle'. As children grow up, most learn that they can make their voices heard, and exercise some power over events, even whilst they are with people who are more powerful than themselves. They discover that, although they may not be able entirely to have their own way, they can exert influence and make others take notice of their wants and opinions. The people we call schizoid, on the contrary, conceive that they can only retain autonomy if they withdraw into isolation. They do not imagine that they can exert any influence over the thoughts or behaviour of others, whom they think of as being both more powerful and more ruthless than themselves. They think of other people as being so entirely oblivious of their needs and wishes that they might as well not exist, and so come to feel that their very being is threatened. R. D. Laing gives a good example of this in his book *The Divided Self*. One patient is arguing with another in the course of a session in an analytic group. One breaks off to say: 'I can't go on. You are arguing in order to have the pleasure of triumphing over me. At best you win an argument. At worst you lose an argument. I am arguing in order to preserve my existence.'[3]

Although at first sight such a statement might seem delusional, there may be more in it literally than meets the eye. Bruno Bettleheim[4], the psychoanalyst who was for a time confined in Auschwitz concentration camp, observed that those prisoners who surrendered autonomy entirely and acquiesced in letting the guards determine their whole existence became like automata – Mussulmen, as they were called – and soon actually died. Survival seemed to depend upon preserving some tiny area in which decision could still be in the hands of the prisoner himself.

The fear of being overborne or engulfed, as Laing calls it, sometimes seems to be the consequence of having been treated with particular lack of consideration as a child; more particularly, of having been treated as a doll or automaton or as an appendage to the parents rather than as a person with a separate existence. The fear has much in common with Freud's 'castration anxiety', in the sense of being deprived of potency or effectiveness.

The impotence of being unable to influence authority has been vividly depicted by the novelist Kafka in his classic novels *The Trial* and *The Castle*.[5,6] According to Kafka's biographer, Max Brod, Kafka continued, throughout his life, to attribute almost magical powers to his father.[7] When he was 36 he wrote a long *Letter to my Father* in which he exposed his continuing sense of inadequacy and his feeling of always being in the wrong which he experienced in relation to his father. The same sense of powerlessness is evident in Kafka's religious attitude. There is an Absolute, but so remote from the life of man that misunderstanding and lack of comprehension is inevitable. Kafka considered that parents were tyrants and slave-drivers. He agreed with Swift that 'parents are the least of all to be trusted with the education of their children'. His novels are concerned with authorities who are so arbitrary and unpredictable that it was impossible to understand them or work out ways of dealing with them.

I wrote earlier that neurotic symptoms were exaggerations of anxieties we all feel. Those who are fortunate enough to possess basic trust in other human beings may find it difficult to empathise with schizoid people because they cannot detect any trace of similar traits in their own personalities. However, even

the most 'normal' people fear revealing intimate secrets to others; for they realise that to do so is to put oneself in the power of the other person. Real intimacy is not lightly embarked on even by those who are not habitually suspicious. The common fear of getting married is often rooted in the idea that to do so might threaten autonomy to a dangerous extent. Many people who pass for normal are unable to conceive of a human relationship in which the partners are on equal terms, in which giving and taking are reciprocal, because they have never experienced such a relationship, and may feel that they themselves have nothing much to give.

A third reason for avoiding intimacy is the subject's fear that he will harm or destroy the person to whom he becomes attached. At first sight this kind of fear may seem to contradict the other varieties since it seems to imply that the subject is more, not less, powerful than the other person. However, the power concerned is of a kind possessed by every child; the power to exhaust or empty the parent. Kleinian analysts would trace such a fear to phantasies arising in the earliest months of life, when a frustrated or greedy infant might suppose that his urgent need had emptied or destroyed the breast upon which his existence depended. However this may be, there is little doubt that older children may come to feel that their capacity to exhaust a parent outweighs the pleasure which the parent may take in their presence, especially if the parent is elderly or ailing. Schizoid adults habitually find that relations with others exhaust them, and so suppose that they themselves must be equally exhausting. This leads to a kind of careful watchfulness which makes spontaneity in human relationships impossible. In some instances, this attitude can be traced to the behaviour of a parent who is also schizoid. Small children are to some extent exhausting to most parents in our culture because their care requires constant vigilance and because they cannot provide the kind of interchange on equal terms which adults find rewarding. However, there are many parents who feel all too easily drained by their children because they themselves cannot play or enter into a child's world through their imagination. A child may thus be faced with a parent who not only does not give him the affection and understanding which he desperately needs, but who also conveys to him that his needs are potentially destructive of the person to whom he turns to fulfill them. This may lead to the conviction that fulfilment through love is unattainable except in phantasy. Close relationships are regarded as mutually exhausting rather than mutually rewarding; and so the safest thing is to avoid them as far as possible.

As we have seen, hysterical and depressive patients are generally anxious to please and therefore tend to make an agreeable first impression upon the therapist. Obsessional patients may be more reserved; but their fear of aggression usually makes them polite and respectful of convention. Some schizoid patients, on the other hand, often make little attempt to please, and may proclaim their disdain for convention by eccentricity in dress, disregard for good manners, and what may often seem to be deliberate lack of response to the utterances of the psychotherapist. Others appear to conform, and may, like obsessional patients, seem exceedingly polite and concerned with formality. Schizoid personalities who seem well adapted to reality sometimes present an impeccable 'persona' which may make their acquaintances, guests, and psychotherapists feel uncomfortable at their own lack of social polish. However, when people of this kind are faced with emotional demands, a child in trouble, or a wife who is depressed, their only recourse is to retreat from involvement. The emotions of others are as threatening as their own unacknowledged feelings, so that, instead of trying to understand or empathise with the person in distress, they shy away and recommend their own prescription, the only one known to them, redoubled self-control. It is only if the therapist understands what lies behind the mask of indifference or superiority which the schizoid patient assumes, and is prepared to control his own resentment at being disregarded or treated cavalierly, that he will be able to penetrate his patient's façade. Most of us maintain our self-esteem because we have fruitful, reinforcing relationships with others which make us feel valued. Although, as we have seen, depressive people are unusually dependent upon outside reinforcement to maintain self-esteem, all of us need this to some degree, and become depressed if we are isolated for any length of time. This was long ago recognised by the Russians who, when they arrest a political prisoner, customarily confine him alone without giving him any information about what is to be done with him or

any news of his family and friends. After about six weeks of emotional isolation in which the prisoner's only exchanges are with gaolers who are forbidden to converse with him except about essentials, most prisoners become profoundly, hopelessly, depressed, and give up trying to care for themselves. Schizoid people are probably better able to stand solitary confinement than normal people because their relationships with others have been so tenuous that to be deprived of them is no great loss. What schizoid persons do is to develop a world of phantasy to compensate for their lack of fulfilment in the real world. Since schizoid persons have failed to obtain love or to achieve relationships on equal terms with anyone else, their phantasy is one in which they themselves play a superior role. If one cannot be loved, one can at least be admired, envied, or regarded with awe. This pose of superiority compounds the difficulty which schizoid people have in making relationships; for others detect it, and, quite naturally, resent it. And thus what began as a phantasy of being disliked or despised tends to become a reality. Some schizoid people attain what may appear to be good relations with others by going to the opposite extreme of the disdain for convention described above. Such a person will be punctiliously polite and exaggeratedly considerate, but those who are the recipients of his attention will tend to feel that his consideration comes from the head and not the heart. In this they will be right. Schizoid people sometimes make quite conscious decisions that it is morally right to be tactful, or generous, or virtuous; and strive to behave in accordance with their adopted principles. However, they will still convey to others their unconscious intention of keeping them at arm's length and fail to meet them on the common ground of shared humanity. St Paul's best known passage on love, from the first epistle to the Corinthians, is directly applicable to schizoid people.

'I may speak in tongues of men or of angels, but if I am without love, I am a sounding gong or a clanging cymbal. I may have the gift of prophecy, and know every hidden truth; I may have faith strong enough to move mountains; but if I have no love I am nothing. I may dole out all I possess, or even give my body to be burnt, but if I have no love, I am none the better.'[8]

Schizoid people, especially if intellectually gifted, may substitute power for love in actuality or phantasy, but the satisfaction which they obtain from this is both limited and precarious, for it seems that it is only the feeling of loving and being loved which is finally effective in dispelling a sense of futility.

In the chapter on obsessional people, I said that they tended to relate to others in terms of domination versus submission, or superiority versus inferiority. This is true to an even greater extent of the schizoid person, although, because of his greater withdrawal from involvement, phantasy plays a more significant part in his relations. Thus, one often discovers that a schizoid person cherishes the notion that he is unusually gifted, or has some special insight into reality (both suppositions may be true), whilst at the same time being terrified of finding himself in the hands of others as if he was powerless to influence or affect them. Phobias of operations, of the dentist, or even of the hairdresser are not uncommon in schizoid patients who conceive that if they go so far as to let anyone do anything to them, they will be in danger of being totally destroyed. Such ideas are delusions in embryo. In understanding the schizoid patient, it is helpful to bear in mind the delusional systems of paranoid schizophrenics. Every psychiatrist is familiar with the patient who believes himself to be extremely important; royalty, or a great inventor, or some other kind of misunderstood genius, but who believes that his true worth is not recognised, and his position taken from him by the machinations of the Catholics or the Freemasons, or some other group of wicked persecutors. Schizoid people, in contrast with schizophrenics, retain sufficient grasp of reality to distinguish at least part of their phantasy life from reality and therefore retain their sanity. Instead of exhibiting frank delusions, they may be touchy, suspicious or litigious. Very often, they refuse to put their phantasied superiority to the test. Some schizoid people who, in youth, were brilliant passers of examinations, fail to live up to their early promise because they dare not expose what they have to offer to the light of criticism, as if they knew that a large element of phantasy entered into their own self-estimate.

Since relationships are conceived of in terms of superiority versus inferiority, the sexual phantasies of schizoid people are often sadomasochistic. Unable to conceive of being loved, they can imagine being admired for their strength, or think of them-

selves as dominating a partner who might otherwise disregard them. Sado-masochistic phantasies are certainly not confined to schizoid people, as their widespread occurrence in pornography demonstrates; though perhaps it might be closer to the truth to say that such literature appeals to a schizoid aspect of human nature which is ubiquitous. But schizoid people cannot imagine any other kind of sexual relationship since their imagination is confined to the childhood situation in which discrepancy of power between child and adult is an inescapable feature. Schizoid women, who are far less commonly encountered than schizoid men, conceive of themselves in a masochistic way, as objects upon whom the man can exercise his strength. Since schizoid people live so much in phantasy, whilst finding it difficult to make actual relationships with real people, they often make use of phantasy during sexual relations. Laing describes a man who could only have intercourse with his wife if he was imagining having intercourse with her. Others make use of phantasies which belong to a childhood phase of development before the child had discovered what sexual intercourse was actually like. Fetishistic and other phantasies of a deviant kind belong to this category. It will be recalled that Freud thought of fetishism in terms of a splitting of the ego, in which one part denied reality, whilst the other continued to accept reality at least in part. The difficulty which schizoid people encounter in establishing ordinary sexual relations may also be described in terms of their alienation from the body, both the bodies of others and their own bodies.

In the last chapter, reference was made to the tendency of obsessional patients toward 'intellectualisation'. Schizoid patients exhibit this tendency to an even greater degree. They exalt the mental at the expense of the physical to the point at which they identify themselves with their minds and are apt to regard their bodies as mere appendages with needs and desires which are often regarded as a nuisance; alien demands which interfere with the true reality, the life of the mind. Proust, who showed a number of schizoid traits, wrote: 'Indeed it is the possession of a body that is the great danger to the mind, to our human and thinking life . . .'[9] Freud defined the ego in terms of the body.[10] 'The ego is first and foremost a body ego, i.e. the ego is ultimately derived from bodily sensations, chiefly from

those springing from the surface of the body.' Schizoid patients, perhaps because of some very early failure in relation with the mother, become 'out of touch' with the body, and, as we have seen, regard being closely 'in touch' with another person as potentially threatening. It is touch which gives most of us our sense of reality, as well as conveying closeness to another person. Although we regard being out of touch with the body as a symptom of disorder when we see it in our patients, it must not be forgotten that man's greatest intellectual achievements depend upon the possibility of disassociating oneself, at least temporarily, from the world of the body. As I demonstrated in *The Dynamics of Creation*,[11] a schizoid personality is probably obligatory for certain kinds of creative achievement. Those who have achieved most in the fields of abstract thought have mostly been solitary people, disinclined to, or incapable of, making close relationships with other human beings. Descartes, for example, refers to the body as possibly illusory, and distrusted the evidence of the senses. It is significant that the first principle of his philosophy, 'I think, therefore I am', makes mind more certain than matter, and, as Bertrand Russell pointed out, 'my mind (for me) more certain than the minds of others'.[12] Although schizoid personalities suffer from their isolation and may, to psychiatric eyes, appear pathological, it must be remembered that detachment from the subjective, which is obligatory for the pursuit of science, is a human capacity of vital significance for our whole adaptation. Scientists confine their objectivity to the laboratory, and are as humanly subjective as anyone else where personal relationships are concerned; but their capacity for detachment could reasonably be described as 'schizoid' although their total personalities are not necessarily of this type. Scientists who behaved 'objectively' to their wives, as if the latter were subjects for experiment rather than persons with whom to relate, would be exhibiting schizoid behaviour.

According to some authorities, regarding the demands of the body as alien to the self belongs to a very early stage of infantile development. Winnicott, for example, writes: 'In the area I am examining the instincts are not yet clearly defined as internal to the infant. The instincts can be as much external as can a clap of thunder or a hit. The infant's ego is building up strength and in consequence is getting toward a stage in which id-demands will

be felt as part of the self, and not as environmental . . .'[13]

I am not primarily concerned with the possible causes of particular types of distorted character formation, since, as I indicated in an earlier passage, the various theories put forward to account for these distortions are impossible, in our present state of knowledge, to prove or disprove. They therefore remain articles of faith which are the source of disputes between the various psychotherapeutic 'schools'. However, I think most psychotherapists who have undertaken the treatment of schizoid patients would agree that it appears that something must have gone wrong between mother and baby at a very early stage of the schizoid patient's development. It is now possible to predict which parents are likely to be successful as parents and which unsuccessful by careful observation of the behaviour and attitudes of mothers during the prenatal period, the time of delivery of the baby, and some weeks after delivery.[14] No doubt many other factors enter into the production of schizoid individuals, including genetics, intelligence level, and experience in later childhood; but I guess that the earliest experience with the mother may turn out to be crucial, since many schizoid patients give a history of having found interaction with others difficult from the moment that they first encountered other children. The Kempes' research was carried out to see if, by conducting careful observations of maternal behaviour before and after the birth of the infant, it would be possible to predict which children would be at risk of physical injury. Their success in predicting which families would show abnormal patterns of parental behaviour is considerable; and I suggest that their techniques could provide a way of proving whether the later development of schizoid traits of character is in fact related to abnormalities of interaction between mother and infant.

Whatever the ultimate cause turns out to be, schizoid individuals develop a mask, or 'persona' as Jung called it, which conceals their feelings both from themselves and from others. It is as if their most basic, primitive, physical needs had somehow been repudiated at a crucial time in their development, with the consequence that they had adopted a pose and a manner of relating which pretended that these basic needs were unimportant. This way of looking at schizoid individuals is closely related to Winnicott's concept of the False Self versus the True

Self. Civilised life demands that we all develop a persona. Indeed, social life would be impossible if we were unable to be polite, show consideration when we ourselves may be tired or out of temper, or sometimes defer to the opinions of others more than we would like for fear of provoking embarrassingly vehement dissent. But with our intimates, and especially with our partners in love, we ought to be able to shed the mask and risk being our vulnerable, emotional selves without constraint. This the schizoid person cannot do. He is terrified that his True Self will be rejected, repudiated, or even annihilated. Over many years he has built up a False Self, based upon compliant identification with others, until he himself finds it hard to recognise what his own deepest feelings really are. This may enable him to get by for many years, with no-one recognising that there is much wrong, although people may complain that he is difficult to know, or that he does not reveal much of himself. Psychiatrists long ago noticed that schizophrenic patients often were described as unusually good, well-behaved children. This compliance with the demands of parents sometimes indicates that a child's true individuality, his 'True Self' is already buried; and the outbreak of psychosis may, as R. D. Laing has emphasised, be an attempt of the True Self to emerge into the light of day. (There are many objections to regarding all cases of schizophrenia in this light, as Laing tends to do; but this way of looking at some 'schizophrenic episodes' in adolescence is fruitful.) Winnicott describes one patient who came to him after having a considerable amount of analysis with other analysts. 'My work really started with him when I made it clear to him that I recognised his non-existence. He made the remark that over the years all the good work done with him had been futile because it had been done on the basis that he existed, whereas he had only existed falsely. When I said that I recognised his non-existence he felt that he had been communicated with for the first time. What he meant was that his True Self that had been hidden away from infancy had now been in communication with his analyst in the only way which was not dangerous.'[15]

Schizoid individuals often feel most real when they are alone. Then their true selves can be allowed to flourish without danger of harm from others. If they happen to be gifted in one of the

arts or sciences, they may find that creative activity is an effective compensation for their lack of close or genuine relationships with other people, and thus avoid suffering from a sense that life is futile or meaningless. As Winnicott observes: 'It is creative apperception more than anything else that makes the individual feel that life is worth living. Contrasted with this is a relationship to external reality which is one of compliance, the world and its details being recognised but only as something to be fitted in with or demanding adaptation. Compliance carries with it a sense of futility for the individual and is associated with the idea that nothing matters and that life is not worth living.'[16] By 'creative apperception' Winnicott means a whole attitude to life; one in which the individual feels that he is able to bring his whole personality into relation with other people and the world. Creative people vary very considerably in personality, as I have shown in *The Dynamics of Creation.*[17] By no means all are predominantly schizoid, and their work need not primarily represent a retreat from real life. But, provided they have the necessary talent, creative work does have a special appeal to those of schizoid temperament because its solitary practice means that they can pursue their own thoughts and phantasies without encountering the withering, shrivelling effect of others' scrutiny. If they then publish a book, or exhibit a picture, they will of course be sensitive to its reception; since it is bound to reveal something of their inner life, their 'true Self'. But the work in which they are thus revealed will display only selected aspects, never the whole person. Moreover, it will have been prepared and polished in such a way as to make it as acceptable as possible. Many creative people feel so sensitive about 'work in progress' that they will not discuss it with anyone else or show it to anyone until it is entirely finished. What is spontaneously produced, before their own critical scrutiny has been brought to bear upon it, cannot be displayed; and this avoidance of spontaneity is a notable feature of the schizoid person's whole adaptation. Some creative people, like Newton, keep their discoveries or their works to themselves; or may profess themselves incapable of finishing them. Newton feared that others would steal his discoveries. Those who cannot complete a book are generally protecting themselves against criticism. Still others, as Fairbairn points out,

pretend that their works, once completed, are no longer of any importance to them. Fairbairn quotes the case of an artist who 'lost all interest in his pictures once they had been painted; and the completed pictures were characteristically either just dumped in the corner of the studio or treated simply as commodities for sale'.[18]

However, the majority of schizoid patients who come the way of the psychotherapist are not creative except in phantasy. The therapist's task is first to recognise the patient's isolation and then so to gain the patient's confidence that the defences which maintain his isolation need not continue. Often, the therapist will find it necessary to make a relationship with the patient in what may seem rather an intellectual fashion to begin with. Schizoid patients are easily frightened by a direct approach to their emotional life. Educated patients of this type will often reveal an interest in literature or the other arts, since these afford an opportunity for emotional expression which does not involve other people. I have found it valuable to explore with such patients what books or music or painting particularly appeal to them. This exploration can lead to a feeling of shared emotional experience which may form a basis upon which the patient feels safe to proceed further. It is important that the therapist is not prematurely discouraged because the patient does not show any immediate response. Progress with these deeply disturbed people is bound to be slow; but, very often, a great deal more is happening during the course of psychotherapy than the patient at first acknowledges or even realises. If, for many years, one's adaptation has been in the direction of doing without other people as far as possible, it is not likely that one will admit a need for them very easily. The most difficult thing for the schizoid patient to give up is his phantasied superiority. Indeed, he may never quite be able to relinquish this, since his whole self-esteem has for years depended upon it. We see this even more clearly in the case of patients who are frankly psychotic. The delusions of the schizophrenic cannot be argued with, because their maintenance has become essential to the patient's conception of himself as a person. If one's only source of self-esteem is the belief that wicked persecutors have deprived one of one's birthright, that belief will not be susceptible to argument. It is only when the

schizoid person comes to believe that other people really care for him that he can afford to abandon his phantasy of superiority: that is, when he has been able to discover that love is a better source of self-esteem than power.

Whereas the delusions of the schizophrenic are private, that is, not shared by other people, which may be one reason why we label him mad, beliefs of an almost equally strange kind may be shared by small numbers of people whose psychopathology often seems to be schizoid. The reason for this is that esoteric beliefs and phantasied superiority go hand in hand. The alienated and the isolated are attracted to strange sects partly because the systems of belief which such sects promulgate hold out the promise of understanding their own difficulties in life, and partly because being a member of such a sect carries with it the implication of possessing more insight into life than the average person. It would be invidious to mention any particular sect, but I cannot forbear to say that, in my opinion, some groups of psychoanalysts comply with this description. There still exist analysts who believe that their particular variety of analysis is the only true key to human understanding; that there is such a thing as being completely, or fully, analysed; and that all those who do not pursue this particular path are consigned to outer darkness. It is analysts of this kind whom I had in mind when, in the chapter on interpretation, I referred to doctrinaire analysts who have not made adequate rapport with their patients and who only understand human nature in terms of a rigid doctrinal scheme.

Schizoid patients present the greatest challenge to the psychotherapist, unless he is one of those bold spirits who works with the frankly psychotic. But, to my mind, they are the most interesting of all the troubled people who consult us, and also those who teach us most about the complexities of human nature.

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